COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

BILINGUAL BONUS AUTHORIZATION/TERMINATION

PLEASE TYPE

EMPLOYEE NAME:	EMPLOYEE NO.:
PAYROLL TITLE"	ITEM NO.:
OFFICE/POGRAM:	PAY LOCATION:

☐ **AUTHORIZATION**

Language required: _____

Skills required: ☐ Speaking ☐ Writing ☐ Reading

Date Certificate issued: _____

Duties requiring use of bilingual skills (be specific):

_____

_____

_____

_____

_____

Average Number of Times Language Used: _____ Per Day _____ Per Week

Date Assignment Begins _____

This is to certify that the employee meets the eligibility criteria established by departmental policy.

☐ I request that a Language Proficiency Examination be administered for the language and skills identified above.

☐ I request bilingual bonus for the employee. _____ _____
District Chief Signature Date

☐ **TERMINATION**

Reason: _____

Date: _____

☐ I authorize termination of bilingual bonus

_____ _____
District Chief Signature Date

PERSONNEL DIVISION USE ONLY

1. Effective Date of Bonus/Termination _____Date Payroll notified _____
2. Reason for denial of request _____

   Date District Chief notified _____

_____ _____
Bilingual Coordinator Signature Date

SEND ORIGINAL AND 3 COPIES TO BILINGUAL COORDINATOR
RETAIN COPY IN OFFICE FILE